WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

2005-06
(session year)

Assembly
(Assembly, Senate or Joint)

Task Force on Medical Malpractice (ATF-MM)

Sample:

Record of Comm. Proceedings ... RCP
- 05hr_AC-Ed_RCP_pt01a
- 05hr_AC-Ed_RCP_pt01b
- 05hr_AC-Ed_RCP_pt02

- *Appointments* ... *Appt*
- **

- *Clearinghouse Rules* ... *CRule*
- **

- *Committee Hearings* ... *CH*
- **

- *Committee Reports* ... *CR*
- **

- *Executive Sessions* ... *ES*
- **

- *Hearing Records* ... *HR*
- **

- *Miscellaneous* ... *Misc*
- **05hr_ATF-MM_Misc_pt11b**

- *Record of Comm. Proceedings* ... *RCP*
- **

Beginning in the Mid-1970s, Groups of Physicians Joined Together to Form Mutual Insurance Companies

Faced with a surge in the frequency and severity of claims, many of the for-profit insurers left the medical malpractice insurance market in the mid-1970s. At the time, medical malpractice insurance was only a small portion of most of the insurers' overall business, so many companies chose simply to discontinue their medical malpractice lines. However, this market exodus led to a crisis of availability for physicians who wanted or needed professional liability insurance. In response to this unmet demand, physicians, often in connection with their state medical societies, joined together to form physician-owned insurance companies. Initially, physicians often needed to contribute capital in addition to their premiums so that the companies would meet state capitalization requirements.

These new physician-owned insurance companies differed from existing commercial carriers in several ways. First, the physician-owned companies wrote predominantly claims-made policies, which, as previously discussed, allowed the insurers to more accurately predict losses and set premium rates. Second, in their initial years the new companies themselves enjoyed significant short-term cost savings over commercial companies. Most medical malpractice claims take several years to be resolved, and the policies offered by the physician-owned companies covered only future incidents of malpractice, so the companies had no existing claims that needed to be paid immediately. The commercial companies' occurrence-based policies continued to provide coverage for malpractice that had occurred before the new physician-owned companies began offering policies. Thus the physician-owned companies would not incur the same level of obligations as the existing carriers for several years, allowing the physicians to pay an amount similar to the commercial premium and use much of that money as capital contributions to surplus. Physician-owned companies have several other advantages. To begin with, physician-owned companies have a cost advantage because they do not need to provide shareholders with profits. In addition, the physician-owned companies may have some underwriting advantages over the for-profit entities, such as an intimate knowledge of local doctors and hospitals and the legal customs and climate. Finally, several insurers told us that these physician-owned companies may have a different management philosophy than for-profit companies, one that places greater emphasis on risk management and thus lowers the incidence of claims. This philosophy may also extend to defending claims more aggressively than traditional insurers.

Physician-owned and/or operated[33] insurance companies have grown to dominate the medical malpractice insurance market, despite the fact that most of them have not had the same access to the traditional capital markets as for-profit insurers and therefore have had to build up their surplus through premiums and capital contributions. Although several physician-owned and/or operated insurance companies have expanded their geographic presence and lines of insurance in the last decade, most of these companies write insurance primarily in one state or a few states and usually sell only medical malpractice liability insurance. Further, many of the companies that had previously expanded have now retreated to their original area and insurance line. As a result of this continuing change in the composition of the medical malpractice insurance market, changes in premium rates in the next soft market may be different from previous markets, when commercial carriers dominated the market.

A Growing Number of Individual Hospitals and Hospital and Physician Groups Have Begun Self-Insuring

Over the past several years, an increasing number of individual hospitals and consortia of hospitals and physicians have begun to self-insure[34] in a variety of ways. Officials from the American Hospital Association estimated that 40 percent of its member hospitals are now self-insured. In states such as Florida that allow individual physicians to self-insure, individual health care providers are also insuring themselves. Other hospitals and groups of physicians are joining alternative risk-sharing mechanisms, such as risk retention groups[35] or trusts.[36] Although some hospitals and physicians have used these alternatives in the past, some industry experts we spoke to said that the increasing movement to such

[33]Some companies that were originally physician-owned have become publicly-held, physician-operated insurers. While those insurers must now earn profits to satisfy shareholders, and thus do not have all of the advantages that strictly physician-owned insurers have, public, physician-operated insurers may have certain other advantages, such as greater access to capital markets.

[34]In general, self-insurance involves protecting against loss by setting aside funds to cover potential claims rather than buying an insurance policy.

[35]A risk retention group is a state-chartered liability insurance company owned by its policyholders that can be formed as a stock or mutual insurance company. However, the Risk Retention Act of 1986 preempts certain aspects of state laws regulating the activities of risk retention groups.

[36]A trust consists of segregated accounts of health care entities that simply estimate liabilities and set aside funds to pay them. Some trusts are not required to have a surplus or reserves.

arrangements under the current market conditions indicates that some health care providers are having difficulty obtaining insurance in the traditional market.

While these arrangements could save money on the administrative costs of insurance, they do not change the underlying costs of claims. Hospitals and physicians insured through these arrangements often assume greater financial responsibility for malpractice than they would under traditional insurance arrangements and thus face a potentially greater risk of insolvency. Although self-insured hospitals generally use excess loss insurance for claims that exceed a certain amount, the hospitals must pay the entire amount up to that threshold. Rather than a known number of smaller payments on an insurance policy, the hospitals risk an unknown number of potentially larger payments. And the threshold for excess loss insurance is rising in a number of states. In Nevada, for example, some hospitals' excess loss insurance used to cover claim amounts in excess of $1 million but now covers amounts above $2 million, leaving self-insured hospitals with $1 million more exposure per claim. Self-insured physicians, who have no other coverage for large losses, risk their personal assets with every claim.

Hospitals and physicians are not the only ones more at risk under these alternative arrangements. Claimants seeking compensation for their injuries may have more difficulty obtaining payments from some of these alternative entities and self-insured hospitals and physicians, for several reasons. First, these entities and the self-insured are subject only to limited public oversight, as state insurance departments do not regulate them. Further, these entities do not participate in the state-run safety nets that pay claims for insolvent insurance companies (state guaranty funds). Once such a risk-sharing consortium fails, claimants may have no other recourse but to try to enforce judgments against physicians personally. But enforcing a judgment against a physician personally is generally more difficult than obtaining payment under an insurance policy from a solvent insurance company.

Data on these forms of insurance are sparse, so the extent to which physicians and hospitals are using such arrangements is difficult to measure. For example, NAIC and state insurance department data do not include information on self-insurance or on most alternative risk-sharing vehicles. In addition, one industry group has estimated that the information available from A.M. Best, a recognized industry data source, accounts for less than half the costs resulting from medical malpractice claims.[37] Like the growth of physician-owned insurance companies, however, the growth of such forms of insurance since the previous soft market may affect the extent to which premium rates change in the next soft market.

All States Have Passed Laws Designed to Reduce the Growth of Medical Malpractice Premium Rates

Since the medical malpractice crisis of the mid-1970s, all states have enacted some change in their laws in order to reduce upward pressure on medical malpractice premiums. Most of these changes are designed to reduce insurers' losses by limiting the number of claims filed, the size of awards and settlements, and the time and costs associated with resolving claims. Other changes are designed to help health care providers by more directly controlling premium rates. Appendix II contains a more detailed explanation of some of the types of legal changes that some states have made, and appendix III contains more detail on the relevant laws in our seven sample states.

Most of the state laws aimed at controlling premium rates attempt to reduce insurer losses related to medical malpractice claims. Many of these laws have similar provisions, the most controversial being the limitation, or cap, on subjective, nonmonetary losses such as pain and suffering (noneconomic damages). Several insurers and medical associations argue that such a cap will help control losses on medical malpractice claims and therefore moderate premium rate increases. But several trial lawyer and consumer rights associations argue that such caps will limit consumers' ability to collect appropriate compensation for their injuries and may not reduce medical malpractice premium rates.

A cap on noneconomic damages may decrease insurers' losses on claims by limiting the overall amount paid out by insurance companies, especially since noneconomic damages can be a substantial portion of losses on some claims. Further, such a limit may also decrease the number of claims

[37]Tillinghast-Towers Perrin, *U.S. Tort Costs: 2002 Update, Trends and Findings on the Costs of the U.S. Tort System* (Atlanta, Ga.: February 2003).

brought against health care providers. Plaintiffs' attorneys are usually paid based on a percentage of what the claimant recovers, and according to some trial attorneys we spoke with, attorneys may be less likely to represent injured parties with minor economic damages if noneconomic damages are limited.

Caps on noneconomic losses may have effects beyond reducing insurers' costs. In theory, for example, after the frequency and severity of losses have been reduced, insurers will decrease premium rates as well. Insurers may also be better able to predict what they will have to pay out in noneconomic damages because they can more easily estimate potential losses, reducing the uncertainty that can give rise to premium rate increases. Insurers reported that economic damages (generally medical costs and lost wages), are more predictable than noneconomic damages, which are generally meant to compensate for pain and suffering and thus are very difficult to quantify.

In addition to attempting to decrease losses on medical malpractice claims, two of our sample states have passed laws directly affecting premium rates and insurance regulations. In a 1988 referendum, California passed Proposition 103, which includes, among other things, a 20 percent rollback of prices[38] for all property-casualty insurers (including medical malpractice insurers), a 1-year moratorium on premium rate increases, and a provision granting consumers the right to challenge any commercial insurance rate increases greater than 15 percent. In 1995, Texas passed legislation that required many insurance carriers, including medical malpractice insurers, to reduce rates to a level deemed by the Texas Department of Insurance to be acceptable, allowing for a reasonable profit. Texas passed the legislation in conjunction with changes to Texas' tort system. The legislators wanted to avoid creating a windfall for insurers and believed that the companies would not lower premium rates on their own until the impact of the changes to the tort system could be actuarially determined.

Interested parties debate the impact these various measures may have had on premium rates. However, a lack of comprehensive data on losses at the insurance company level makes measuring the precise impact of the measures impossible. As noted earlier, in the vast majority of cases,

[38]The California Supreme Court allowed companies to decrease prices less than 20 percent if a company could show that the rollback would make it impossible to earn a reasonable profit.

existing data do not categorize losses on claims as economic or noneconomic, so it is not possible to quantify the impact of a cap on noneconomic damages on insurers' losses. Similarly, it is not possible to show exactly how much a cap would affect claim frequency or claims-handling costs. In addition, while most claims are settled and caps apply only to trial verdicts, some insurers and actuaries told us that limits on damages would still have an indirect impact on settlements by limiting potential damages should the claims go to trial. But given the limitations on measuring the impact of caps on trial verdicts, an indirect impact would be even more difficult to measure. Further, state laws differ dramatically, so comparing their impact is difficult. For example, limitations on damages can vary drastically in amount, type of damages covered, and how the limitations apply. Some states have caps of $250,000 on noneconomic damages, while other states have caps up to several times that amount. Moreover, some dollar limits change over time—for instance, because they are indexed to inflation—while others do not. Some states apply the cap to all damages, including economic damages, and some apply the cap "per occurrence" of malpractice. That is, the total amount collected by all parties injured by an act of medical malpractice cannot exceed the cap, regardless of how many physicians, hospitals, or other health care providers may be partially liable for the injuries. In contrast, for example, Nevada's recently passed limitations on damages allow multiple plaintiffs to collect the full limit from any number of responsible defendants.

The filing and resolution of medical malpractice claims is regulated, to a great extent, by states' tort and insurance laws. Changes to such laws can thus have a great effect on both the frequency and severity of those claims, which in turn can affect premium rates. Because many states have made changes to these laws, it is difficult to predict the extent to which premium rates might change in future markets.

Conclusions

Multiple factors have combined to increase medical malpractice premium rates over the past several years, but losses on medical malpractice claims appear to be the primary driver of increased premium rates in the long term. Such losses are by far the largest component of insurer costs, and in the long run, premium rates are set at a level designed to cover anticipated costs. However, the year-to-year increase in premium rates can vary substantially because of perceived future losses and a variety of other factors, including investment returns and reinsurance rates. Moreover, the market for medical malpractice insurance is not national, but depends on the varying framework of insurance, legal, and health care structures

within each of the states. As a result, both the extent and the effects of changes in losses and other insurance-related factors on premium rates also vary by state.

While losses aggregated for the industry as a whole have shown a relatively consistent upward trend over time, the loss experience of any single company is likely to vary from year to year and to increase more rapidly in some years than in others. At the same time, because of the long lag between collecting premium income and paying on claims, premium rates for the next year must be high enough to cover claims that will be reported that year, the majority of which will be paid over the next 3 to 5 years. And due to the volatility of the ultimate payouts on medical malpractice claims, it is difficult for insurers to predict the amount of those payouts with great certainty. As a result, changes in current losses can have large effects on perceived or estimated future losses and consequently on premium rates, because if insurers underestimate what will be needed to pay claims, they risk not only future profits but potentially their solvency.

However, factors other than losses–such as changes in investment income or the competitive environment–can also affect premium rate decisions in the short run. These factors can either amplify or reduce the effect of losses on premium rates. For example, high expected returns on investment may legitimately permit insurers to price insurance below the expected cost of paying claims. But incorrect projections of continuing high returns could cause insurers to continue to hold prices down for too long, even though underlying losses may be rising. When such factors affect most or all medical malpractice insurers, the result appears as a period of stable or falling premium rates or a period of sharply rising rates. When they alternate, these periods may describe the soft and hard phases of the medical malpractice insurance cycle.

Based on available data, as well as our discussions with insurance industry participants, a variety of factors combined to explain the malpractice insurance cycle that produced several years of relatively stable premium rates in the 1990s followed by the severe premium rate increases of the past few years. To begin with, insurer losses anticipated in the late 1980s did not materialize as projected, so insurers went into the 1990s with reserves and premium rates that proved to be higher than the actual losses they would experience. At the same time, insurers began a decade of high investment returns. This emerging profitability encouraged insurers to expand their market share, as both the downward adjustment of loss reserves and high investment returns increased insurers' income. As a result, insurers were

generally able to keep premium rates flat or even reduce them, although the medical malpractice market as a whole continued to experience modestly increasing underlying losses throughout the decade. Finally, by the mid- to late 1990s, as excess reserves were exhausted and investment income fell below expectations, insurers' profitability declined. Regulators found that some insurers were insolvent, with insufficient reserves and capital to pay future claims. In 2001, one of the two largest medical malpractice insurers, which sold insurance in almost every state, determined that medical malpractice was a line of insurance that was too unpredictable to be profitable over the long term. Alternatively, some companies decided that, at a minimum, they needed to reduce their size and consolidate their markets. These actions, taken together, reduced the availability of medical malpractice insurance, at least in some states, further exacerbating the insurance crisis. As a result of all of these factors, insurers continuing to sell medical malpractice insurance requested and received large rate increases in many states. It remains to be seen whether these increases will, as occurred in the 1980s, be found to have exceeded those necessary to pay for future claims losses, thus contributing to the beginning of the next insurance cycle.

While this explanation accounts for observed events in the market for medical malpractice insurance, it does not provide answers to other important questions about the market for medical malpractice insurance, including an explanation of the causes of rising losses over time. The data currently collected do not permit many of the analyses that would provide answers to these questions. This lack of data is due, in part, to the nature of NAIC's and states' regulatory reporting requirements for all lines of insurance, which focus primarily on the information needed to evaluate a company's solvency. Most insurance regulators do not collect the data that would allow analyses of the severity and frequency of medical malpractice claims for individual insurer operations within specific states. Moreover, insurers are generally not required to submit to NAIC or state regulators data that would show how insurers losses are divided between settlements and trial verdicts or between economic and noneconomic damages. Finally, the increasing use of insurance or self-insurance mechanisms that are not subject to state or NAIC reporting requirements further complicates a complete analysis. While more complete insurance data would help provide better answers to questions about how the medical malpractice insurance market is working, other data would be equally important for analyzing the underlying causes of rising malpractice losses and associated costs. These data relate to factors outside the insurance industry, such as policies, practices, and outcomes in both the medical and legal arenas.

However, collecting and analyzing such data were beyond the scope of this report.

Matter for Congressional Consideration

Health care providers have suffered through three medical malpractice insurance "crises" in the past 30 years. Each instance has generated competing claims about the extent of the problem, the causes, and the possible solutions. In each instance, a lack of necessary data has hindered and continues to hinder the efforts of Congress, state regulators, and others to carefully analyze the problem and the effectiveness of the solutions that have been tried. Because of the potential for future crises, and in order to facilitate the evaluation of legislative remedies put in place by various levels of government, Congress may want to consider taking steps to ensure that additional and better data are collected. Specifically, Congress may want to consider encouraging NAIC and state insurance regulators to identify the types of data that are necessary to properly evaluate the medical malpractice insurance market—specifically, the frequency, severity, and causes of losses—and begin collecting these data in a form that would allow appropriate analysis. Included in this process would be an analysis of the costs and benefits of collecting such data, as well as the extent to which some segments of this market are not captured by current data-gathering efforts. Such data could serve the interests of state and federal governments and allow both to better understand the causes of recurring crises in the medical malpractice insurance market and formulate the most appropriate and effective solutions.

NAIC Comments and Our Evaluation

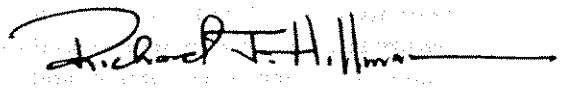
NAIC's Director of Research provided us with oral comments on a draft of this report. The Director generally agreed with the report's findings, conclusions, and matter for congressional consideration. Specifically, the Director agreed that the medical malpractice markets are not national in nature and vary widely with regard to their insurance markets, regulatory framework, legal environment, and health care structures. Furthermore, the Director stated that the medical malpractice insurance industry has shown an upward trend in losses over time and that this rise can be attributed to a variety of causes that are difficult to measure or quantify. The Director also said that he does not believe that excess profits by insurers are in evidence.

The Director told us that NAIC is working on a study of the medical malpractice marketplace that he hopes will be ready for distribution in the

summer of 2003. The Director stated that NAIC, like GAO, had identified many data limitations that make the study of this line of insurance difficult. As a result, the Director generally agreed with our matter for congressional consideration that Congress consider encouraging NAIC and state regulators to identify and collect additional information that could be used to properly evaluate the medical malpractice insurance market. The Director stated that while such efforts would require some additional resources, the costs would not be prohibitive and the efforts would provide needed information. The Director also provided technical comments, which we have incorporated into the report as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the Chairmen of the Senate Committee on Governmental Affairs and its Subcommittee on Oversight of Government Management, the Federal Workforce, and the District of Columbia; the Chairman of the House Committee on the Judiciary; and the Chairman of the House Committee on Energy and Commerce. We will also send copies of this report to other interested congressional committees and members, and we will make copies available to others on request. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staffs have any questions regarding this report, please contact me or Lawrence Cluff at (202) 512-8678. Additional contributors are acknowledged in appendix IV.



Richard J. Hillman
Director, Financial Markets and
Community Investment

List of Requesters

The Honorable Richard J. Durbin
Ranking Minority Member
Subcommittee on Oversight of Government Managment,
the Federal Workforce, and the District of Columbia
Committee on Governmental Affairs
United States Senate

The Honorable John Conyers, Jr.
Ranking Minority Member
Committee on the Judiciary
House of Representatives

The Honorable John D. Dingell
Ranking Minority Member
Committee on Energy and Commerce
House of Representatives

The Honorable Marion Berry
The Honorable Joseph M. Hoeffel
The Honorable Alan B. Mollohan
The Honorable Dennis Moore
The Honorable Nick J. Rahall II
The Honorable Max Sandlin
House of Representatives

Scope and Methodology

Recognizing that the medical malpractice market can vary considerably across states, we judgmentally selected a sample of seven states in order to conduct a more in-depth review in each of those states. Except where otherwise noted, our analyses were limited to these states. We selected our sample so that we would have a mix of states based on the following characteristics: extent of recent increases in premium rates, status as an American Medical Association crisis state, presence of caps on noneconomic damages, state population, and aggregate loss ratio for medical malpractice insurers within the state. The states we selected were California, Florida, Minnesota, Mississippi, Nevada, Pennsylvania, and Texas. Within each state we spoke to one or both of the two largest and currently active sellers of medical malpractice insurance, the state insurance regulator, and the state association of trial attorneys. In six states, we spoke to the state medical association, and in five states, we spoke to the state hospital association. Due to time constraints, we did not speak to the medical or hospital associations in Texas or the hospital association in Florida. We used information obtained from these organizations to help answer each of our objectives and, as outlined below, also performed additional work for each objective.

To examine the extent of increases in medical malpractice insurance rates for the largest insurers in our sample states, we reviewed annual survey data on medical malpractice premium rates collected by a private data collection company. While individual insurers determine whether to respond to the survey, we believe the data to be representative for the three medical specialties for which the company collects data—internal medicine, general surgery, and obstetrics/gynecology—because of both the number of insurers responding to the survey and the states represented by them. The premium rates collected in the survey are base rates, which do not reflect discounts or additional charges by insurers, so the actual premium rates charged by insurers can vary from the premium rates collected in the survey. We could not determine the extent to which the actual premium rates charged varied from the base rates, but among the insurers we spoke with, the actual premium rates charged in 2001 and 2002 ranged from about 50 to 100 percent of the base rates. We did not test the reliability of the survey data.

To analyze the factors contributing to the premium rate increases in our sample states and other states, we examined data from state insurance regulators, the National Association of Insurance Commissioners (NAIC), A.M. Best, the Securities and Exchange Commission, and the Physician Insurers Association of America on insurers in our sample states as well as

the medical malpractice insurance market as a whole. We did not verify the reliability of these data. Where possible, we obtained data from 1975 to the present. As noted earlier in this report, comprehensive, reliable data that would have allowed us to quantify the effect of individual factors on medical malpractice premium rates did not exist. We also reviewed relevant academic studies and industry guidance. In addition, we spoke with officials from the insurers and state insurance departments in our sample states, as well as professional actuarial and insurance organizations. To analyze factors that were likely to vary among states—losses on medical malpractice claims, reinsurance rates, and competition among insurers—we reviewed data for one or both of the two largest and active medical malpractice insurers in our samples states. We also reviewed aggregate data on losses for all insurers in each state as well as the U.S. medical malpractice insurance market as a whole. To analyze factors that were likely to be common among medical malpractice insurers in all states—investment income and the presence of an insurance cycle—we reviewed either A.M Best data for the 15 largest medical malpractice insurers as of 2001 (whose combined market share nationally was approximately 64.3 percent), or NAIC data for all medical malpractice insurers reporting data to NAIC. Also as noted earlier in this report, data and scope limitations prevented us from fully analyzing the factors behind increased losses from medical malpractice claims.

To analyze how the national medical malpractice insurance market has changed since previous periods of rising premium rates, we reviewed studies published by NAIC; analyzed insurance industry data compiled by NAIC and A.M. Best; reviewed tort laws across all states and state insurance regulations; spoke with insurers and state insurance regulators in our sample states; and spoke with officials from national professional actuarial, insurance, legal, consumer rights, medical, and hospital organizations.

We conducted our work from July 2002 through June 2003 in accordance with generally accepted government auditing standards.

Legal Summary

Each state's tort laws generally govern the way in which medical malpractice claims or lawsuits are resolved. As discussed in this report, most state laws aimed at controlling premium rates attempt to reduce insurer losses related to medical malpractice claims. Although these laws take many different forms, they usually have at least some of the provisions summarized in this appendix. State courts have dealt differently with these kinds of provisions, and some states have found that some of these kinds of provisions are unconstitutional. The provisions summarized in this appendix are not the only ones that might impact the treatment of medical malpractice claims in states' tort systems.

Limits on Damages. Damages in medical malpractice cases usually consist of two categories, economic damages and noneconomic damages. (Although punitive damages can be available in cases of gross negligence and outrageous conduct of the health care provider, juries rarely award punitive damages in medical malpractice cases.) Economic damages generally consist of past and future monetary damages, such as lost wages or medical expenses. Noneconomic damages generally consist of past and future subjective, non-monetary loss, including pain, suffering, marital losses, and anguish. Although some states have limits on the total amount of damages recoverable in a medical malpractice suit, most states with limits, as well as pending federal legislation, have emphasized a limit only on noneconomic damages. As discussed in this report, limitations on damages can vary drastically in amount, type of damages covered, and application.

As mentioned in this report, limitations on damages can impact frequency of lawsuits as well. Plaintiffs' attorneys are usually paid based on a percentage of what the claimant recovers, and according to some trial attorneys we spoke to, attorneys may be less likely to represent an injured party with minor economic damages if noneconomic damages are limited. One consumer rights group told us that suits with limited economic damages are typical in cases where the plaintiff is not working and does not have substantial costs of future medical care.

Evidence of Collateral Source Payments. At common law, or without any legislative intervention, a plaintiff would be able to recover all damages sustained from a liable defendant, even if the plaintiff were going to receive money from other sources, called "collateral sources," like health insurance policies or Social Security. Some states have modified this common law rule with statutes that allow defendants to show that the claimant is going to receive funds from collateral sources that will

compensate the claimant for damages he or she is attempting to collect from the defendant. These statutes authorize, to various extents, decreasing the defendant's liability by the amount the claimant will receive from other sources. In the state summaries in appendix III, if a state has not modified the common law rule regarding collateral sources, the chart will say "no modification."

Joint and Several Liability. Joint and several liability is the common law rule that a plaintiff can collect the entire judgment from any liable defendant, regardless of how much of the harm that defendant's actions caused. Some states have eliminated joint and several liability, making each defendant responsible for only the amount or share of damage he or she caused the plaintiff. Other states have eliminated joint and several liability only for noneconomic damages. Some states have eliminated joint and several liability for defendants responsible for less than a specified percentage of the plaintiff's harm; for example, if a defendant is less than 50 percent responsible, that defendant might need to pay only for that percentage of the plaintiff's damages.

Attorney Contingency Fees. Most plaintiff attorneys are paid on a contingency fee basis. A contingency fee is one in which the lawyer, instead of charging an hourly fee for services, agrees to accept a percentage of the recovery if the plaintiff wins or settles. Some states have laws that limit attorney contingency fees. For example, in California a plaintiff's attorney can collect up to 40 percent of the first $50,000 recovered, 33 percent of the next $50,000 recovered, 25 percent of the next $500,000 recovered, and 15 percent of any amount exceeding $600,000. Provisions that decrease attorneys' financial incentives to accept cases could decrease the number of attorneys willing to take the cases. These limits were based on the belief that they would lead to more selective screening by plaintiffs' attorneys to ensure that the claims filed had merit. In the state summaries in appendix III, if a state does not have limits in place specifically for attorneys in medical malpractice cases, the chart will say "no modification."

Statute of Limitations. The amount of time a plaintiff has to file a claim is known as the "statute of limitations." Some states have reduced their statutes of limitations on medical malpractice claims. This decrease could limit the number of cases filed by claimants. Special time requirements for minors are not noted on the summaries in appendix III.

Periodic Payment of Damages. Defendants traditionally pay damages in a lump sum, even if they are being collected for future time periods, such as

future medical care or future lost wages. However, some states allow or require certain damages to be paid over time, such as over the life of the injured party or period of disability, either through the purchase of an annuity or through self-funding by institutional defendants. Some insurers we spoke with said that purchasing annuities can reduce insurers' costs, and that periodic payments better match damage payments to future medical costs and lost earnings incurred by injured parties, assuring that money will be available to the injured party in the future. A consumer rights group we spoke with told us that, because periodic payments stop at the death of an injured party, there may be unsatisfied medical bills at the time of the injured party's death.

Expert Certification. Many states require that medical experts certify in one way or another the validity of the claimant's case. These statutes are designed in part to keep cases without merit, also known as frivolous cases, out of court. Expert certification requirements also have the potential to get as many relevant facts out in the open as early as possible, so that settlement discussions are fruitful and it becomes unnecessary to take as many cases to trial, thus decreasing the claims-handling costs of the case.

Arbitration. Some states have enacted arbitration statutes that address medical malpractice claims specifically. Some of these statutes require that the arbitration agreement meets standards that are designed to alert the patient to the fact that he is waiving a jury trial through the use of a specific size of font, or by specifying the precise wording that must be contained in the agreement. Although most courts have held that medical malpractice claims can properly be submitted to arbitration, litigation involving the arbitration statutes has involved issues such as whether the patient knew he was waiving the right to a jury trial, whether the patient who agrees to arbitration had appropriate bargaining strength, and whether third parties have authority to bind others to arbitration.

By providing an option for arbitration, parties can avoid the larger expense of taking claims to court. However, some industry experts said that these arbitration provisions may not be binding and may result in the losing party deciding to take the case to court in any event, so arbitration can simply increase expenses without affecting the ultimate resolution of the dispute.

Advanced Notice of Claim. Advanced-notice-of-claim provisions require claimants to give defendants some period of time, 90 days for example, prior to filing suit in court. Some insurers and plaintiffs' attorneys we spoke with said that this requirement aids plaintiffs and defendants in resolving meritorious claims outside of the court system and allows plaintiffs' attorneys to obtain relevant records to determine whether a case has merit. However, another group we spoke to said that the advanced notice of claim provision in that group's state was ineffective.

Bad Faith Claims. As mentioned in this report, some insurers we spoke with told us that they can be liable for amounts beyond an insurance policy's limits, if the policyholder requests the insurer to settle with the plaintiff for an amount equal to or less than the policy limit, and the insurer takes the case to trial, loses, and a judgment is entered in an amount greater than the policy limits. Industry experts we spoke to said that, under those circumstances, the insurer could be liable for acting in "bad faith." In some states, like Nevada, this bad faith claim can be brought only by the insured physician; that is, the physician can seek payment from the insurance company if the physician has paid a plaintiff beyond a policy's limits. In contrast, in Florida, the plaintiff can sue a physician's insurer directly for the insurer's alleged improper conduct in medical malpractice cases. The difficulty of establishing that an insurer acted in bad faith varies according to state law. Insurers in three of our study states—Texas, California, and Florida—said that bad faith litigation was a substantial issue in their states.

State Summaries

This appendix describes the specific medical malpractice insurance environment in each the seven sample states we evaluated for this report. (See figs.10-16.)

Market Description

- Typical Coverage Type and Limit. This section summarizes the type of medical malpractice insurance coverage typically issued in the state, as well as the standard coverage limits of these policies. Coverage limits can range from $100,000/$300,000 to up to $2 million /$6 million. The lower number is the amount the insurer will pay per claim and the higher number is the total the insurer will pay in aggregate for all claims during a policy period. There are several types of insurance coverage available.
  - *Occurrence-based* insurance provides coverage for claims that arise from incidents that occur during the time the insurance policy is in force, even if the policy is not continued. Claims that arise from incidents occurring during the policy period that are reported after the policy's cancellation date are still covered in the future.
  - *Claims-made* insurance provides coverage for claims that arise from incidents that occur and are reported during the time the insurance policy is in force.
  - *Prior acts coverage* is a supplement to a claims-made policy that can be purchased from a new carrier when changing carriers. Prior acts coverage covers incidents that occurred prior to the switch to a new carrier but had not been previously reported.
  - *Tail coverage* is an option available from a former carrier to continue coverage for those dates that the claims-made coverage was in effect.
- Regional Differences. This section notes any major regional differences in premium rates quoted by insurers within the state using the base rate for general surgery as a comparison. The *Medical Liability Monitor* annually surveys providers of medical malpractice insurance to obtain their premium base rates for three specialties: internal medicine, obstetrics/gynecology, and general surgery. In the state summaries, descriptions of regional differences in premium rates are based on Medical Liability Monitor information.

- Frequency and Severity. This section describes the extent to which insurers and state regulators we spoke with believe frequency and severity are changing in each state. Frequency is usually defined as the number of claims per number of doctors, counting doctors in different specialties as more or fewer doctors depending on the risk associated with the specialty. Severity is the average loss to the insurer per claim.

Insurer Characteristics and Market Share

- Insurer Characteristics. This section describes the various types of insurers present in each of the states. In addition to traditional commercial insurance companies, the following entities or arrangements can provide liability protection:
  - *Physician insurer associations or physician mutuals* are physician owned and operated insurance companies that provide medical liability insurance.
  - *Reciprocals* are similar to mutuals, except that an attorney-in-fact often manages the reciprocal.
  - *Risk retention groups* are insurance companies owned by policyholders. Risk retention groups are organized under federal law—the Liability Risk Retention Act of 1986.
  - *Trusts* are a form of self-insurance and consist of segregated accounts of health care entities that estimate liabilities and set aside funds to cover them.
- Market Share. This section describes the medical malpractice market in each of the states. Recent changes in the market are also noted in this section.
- Joint Underwriting Association (JUA). This section details whether a state has created a JUA and the extent of its use. A JUA is a state-sponsored association of insurance companies formed with statutory approval from the state for the express purpose of providing certain insurance to the public.

Rate Regulation

This section describes the regulatory scheme employed by each state. Statutory requirements generally provide that insurance rates be adequate,

not excessive, and not unfairly discriminatory. The degree of regulation of medical malpractice insurance rates varies from state to state. States may have "prior approval" requirements in which all rates must be filed with the insurance department before use and must be either approved or disapproved by the department of insurance. Other states have "file and use" provisions in which the insurers must file their rates with the state's insurance department; however, the rates may be used without the department's prior approval.

State Tort Laws

This section identifies key components of each state's efforts to address the medical malpractice insurance situation by targeting ways in which medical malpractice claims are processed through the court system. The following legal provisions are summarized for each state:

- Limits on Damage Awards
- Collateral Source Rule
- Periodic Award Payments
- Pretrial Expert Certification
- Attorney Contingency Fees
- Joint and Several Liability
- Statute of Limitations
- Bad Faith Claims

Appendix II has a description of each of these provisions, in addition to other provisions that are not summarized herein, but that might impact medical malpractice claims. For the information on state provisions in appendix III, we relied upon a summary of state tort laws compiled by the National Conference of State Legislatures (NCSL) in October of 2002. We independently reviewed selected sections of the NCSL summary for accuracy, and supplemented the NCSL information with information from interviews with industry officials. The state laws summarized herein might have changed since the date of the NCSL publication. Additionally, as noted in appendix II, the state tort laws summarized in this appendix are not the

only ones that might impact the treatment of medical malpractice claims in states' tort systems.

Figure 10: California

California

Market description:

Typical coverage type and limit-- Coverage is predominately claims-made. Typical policy limits are $1 million per incident/$3 million cumulative for the policy year.

Regional differences-- Insurers generally divide California into two rating areas-northern and southern California. Insurers typically reported higher rates for general surgery in southern California counties.

Frequency and severity-- The California Department of Insurance (CDI) and insurers believe severity is increasing in California and has led to increases in insurer losses.

State specifics

Population:	33,871,648
Size (land area):	155,959 sq miles
Density:	217.2 pp/sq. mi

Insurer characteristics and market share:

Insurer characteristics-- The California Medical Association stated that most physicians in California purchase medical malpractice coverage from physician owned companies (Doctors Co., MIEC, Norcal), commercial carriers (SCIPIE), or CAP/MPT, a physician cooperative in which physicians assume responsibility for the liabilities.

Market share-- Based on A.M. Best and NAIC data, the companies with a 5% or more market share in California (2001) were Norcal (21%), SCIPIE (13%), Doctor's Co. (11%), CAP/MPT (9%), and Truck Insurance Exchange (6%).

Rate regulation:

Prior to 1988 and the passage of Proposition 103, California had an open filing system and had limited interaction with its malpractice insurers. Proposition 103 requires prior approval of insurer rates. Additionally, if a commercial carrier requests an increase of greater than 15 percent, the Commissioner of Insurance must grant a public hearing upon request. At the time of passage, insurers were also required to roll back their rates by giving a refund to their clients.

State tort laws:

Limits on damage awards-- $250,000 limit on noneconomic damages, applied per occurrence, and not indexed for inflation.

Collateral source rule-- Discretionary offset for collateral sources introduced at trial.

Periodic award payments-- Mandatory periodic payment of future damages over $50,000 (upon request).

Pretrial expert certification-- Generally, no expert certification is required for medical malpractice cases in California.

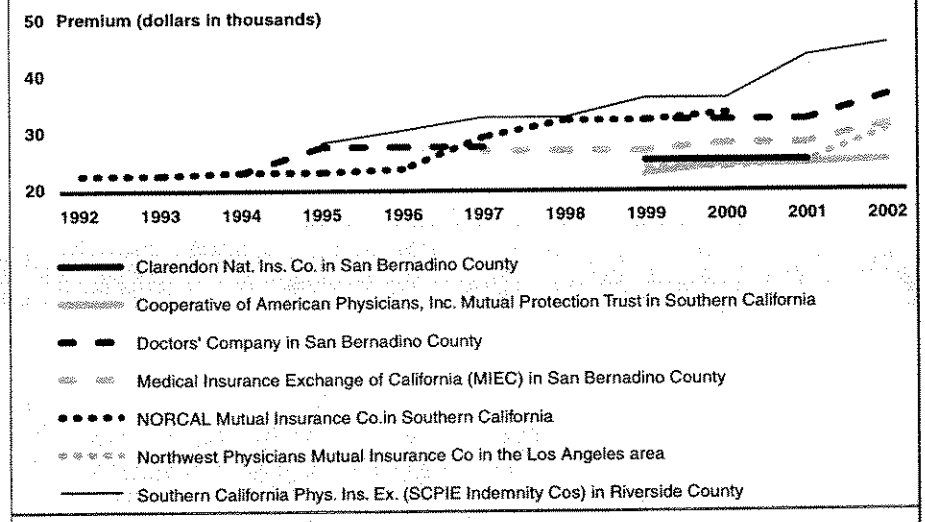
Attorney contingency fees-- Limited to 40% of the first $50,000, 33.3% of the next $50,000, and 25% of the next $500,000, and 15% of any amount exceeding $600,000.

Joint and several liability-- No joint and several liability for noneconomic damages.

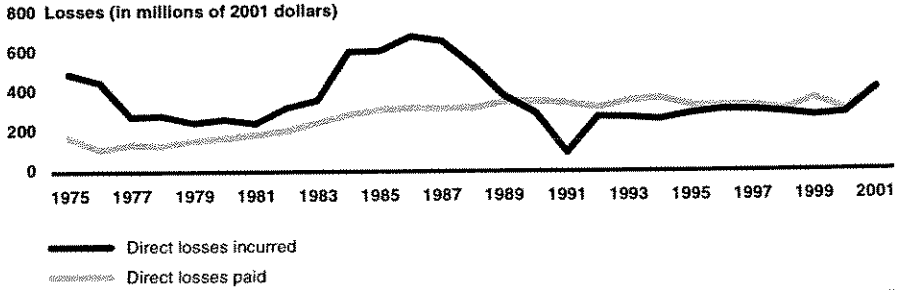
Statute of limitations-- Plaintiffs must file within one year of discovery of injury or within three years of the injury, whichever is first.

Bad faith claims-- Insurers consider this to be a significant problem in California.

Premium Rates: General Surgery for Seven California Insurers ($1M/$3M mature claims-made coverage)



Direct Losses Paid Compared to Direct Losses Incurred California 1975-2001



Sources: U.S. Census Bureau, 2000 (top box); GAO analysis of *Medical Liability Monitor* data (middle box); GAO analysis of A.M. Best data (bottom box).

Figure 11: Florida

Florida

Market description:

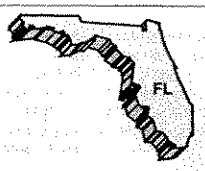
Typical coverage type and limit-- Many physicians are reducing the amount of coverage purchased. For example, in 2002, First Professionals Insurance Company (FPIC) sold almost exclusively claims-made policies with a $250,000 limit.

Regional differences-- Insurers typically reported higher rates for general surgery in Dade and Broward Counties. According to the Florida Medical Association (FMA), Dade County has the highest premium rates in the United States.

Frequency and severity-- FPIC believes claim frequency and severity have gone up significantly in the last several years, with frequency responsible for the increased insurer losses.

State specifics

Population:	15,982,378
Size (land area):	53,927 sq miles
Density:	296.4 pp/sq. mi



Insurer characteristics and market share:

Insurer characteristics-- FMA stated that very few insurers in Florida are currently physician owned. The state Department of Insurance (DOI) believes more hospitals are self-insuring, more doctors are using the state JUA, and many doctors are going without insurance. FPIC--currently writing in 6 states--will only write in Florida beginning in 2003.

Market share-- Based on A.M. Best and NAIC data, the companies with a 5% or more market share in Florida (2001) were FPIC (17%), Health Care Indemnity Inc. (14%), Pronational Insurance Company (9%), and Truck Insurance Exchange (5.4%).

Joint Underwriting Association-- Florida has a JUA, which acts as an insurer of last resort. The number of health care providers using the JUA has increased from around 20 in 2000 to 400 in 2001

Rate regulation:

Florida is a use and file state. There is no allowable deviation from the approved rate filing, which must include all possible adjustments to the base rate.

State tort laws:

Limits on damage awards-- Where parties agree to binding arbitration (requires defendant admit fault), noneconomic damages are limited to $250,000; where plaintiff refuses to arbitrate, noneconomic damages are limited to $350,000. The limits are applied per plaintiff.

Collateral source rule-- Mandatory offset of collateral sources by court, unless sources have subrogation rights.

Periodic award payments-- Periodic payment of future damages allowed if damages exceed $250,000.

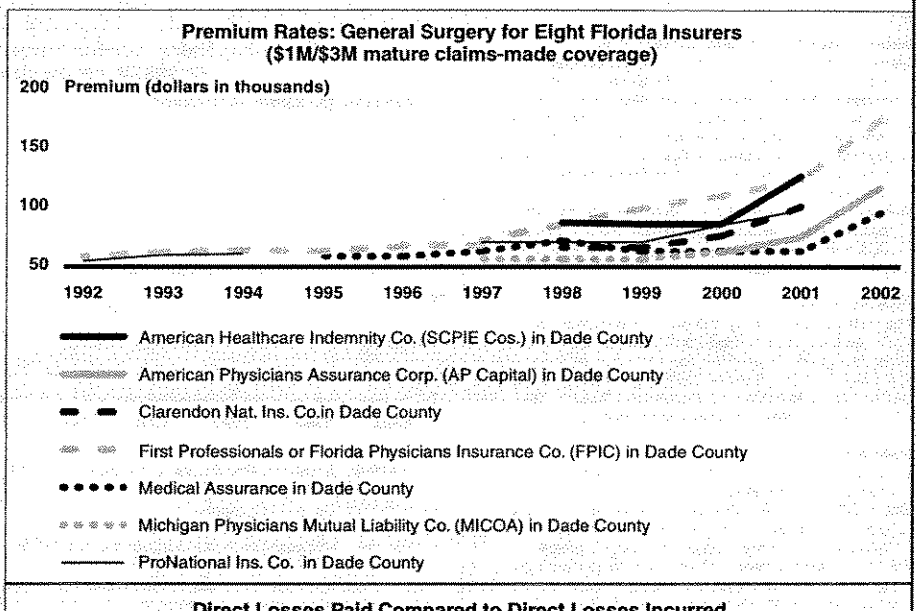
Pretrial expert certification-- Verified medical expert opinion required at the time of notice of intent to initiate litigation.

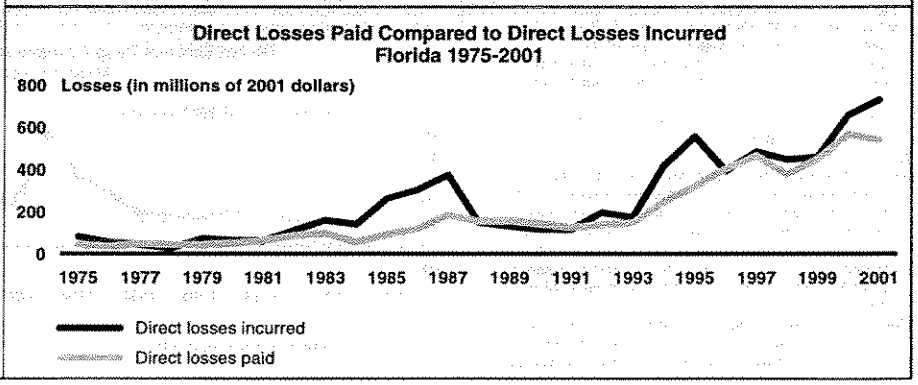
Attorney contingency fees-- Separate sliding scales for cases settling at various points of the judicial process.

Joint and several liability-- Sliding scale for defendant's responsibility, depending on whether plaintiff had any responsibility for harm and how responsible the defendant is for the harm. For example, if the plaintiff is not at fault and the defendant is less than 10% responsible, the defendant need not pay more than the percentage for which defendant was found responsible.

Statute of limitations-- Plaintiff must file within two years of occurrence or discovery, but not more than four years from occurrence.

Bad faith claims-- The Florida Department of Insurance said that bad faith lawsuits are having a significant impact on insurer losses and, therefore, on premium rates.





Sources: U.S. Census Bureau, 2000 (top box); GAO analysis of *Medical Liability Monitor* data (middle box); GAO analysis of A.M. Best data (bottom box).

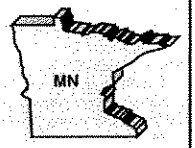
Figure 12: Minnesota

Minnesota

Market description:
Typical coverage type and limit-- Coverage is predominately claims-made. Typical policy limits are $1 million per incident/$3 million cumulative for the policy year, although some physicians purchase $2 million /$4 million coverage.
Regional differences-- Insurers typically treat Minnesota as single rating area.
Frequency and severity-- According to the Minnesota Medical Association (MMA), there has been a slight increase in the severity of claims in the past several years and no observed increase in frequency.

State specifics

Population:	4,919,479
Size (land area):	79,610 sq miles
Density:	61.8 pp/sq. mi

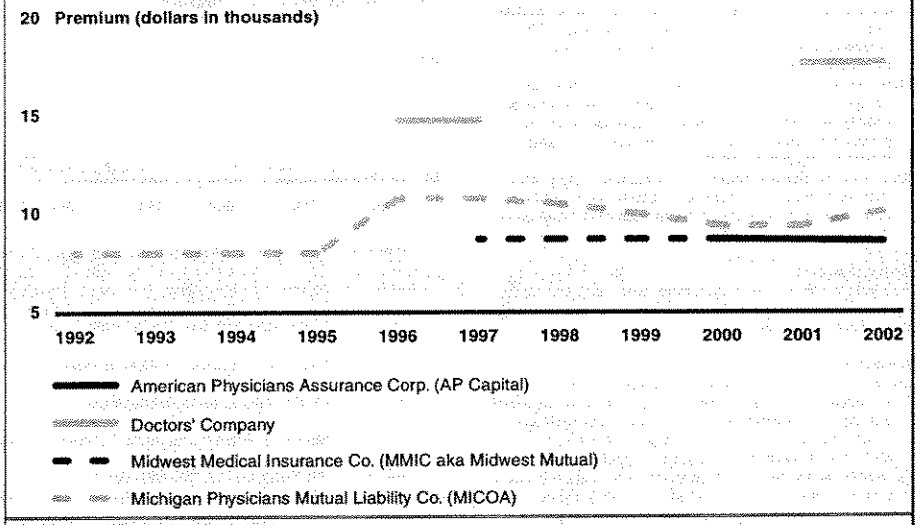


Insurer characteristics and market share:
Market share-- According to A.M. Best, the companies with a 5% or more market share in Minnesota in 2001 were Midwest Medical Insurance Company (51%) and St. Paul (26%). The St. Paul Companies recently discontinued their medical malpractice insurance line in Minnesota. Midwest Medical Insurance Company is now the leading medical malpractice insurer in Minnesota; it grew over 50% in the last two years.
Joint Underwriting Association-- In Minnesota, the JUA is considered the insurer of last resort. As of 1/2002, the JUA had 8 policies but by 10/2002 it had 168 policies, mostly for nursing homes.

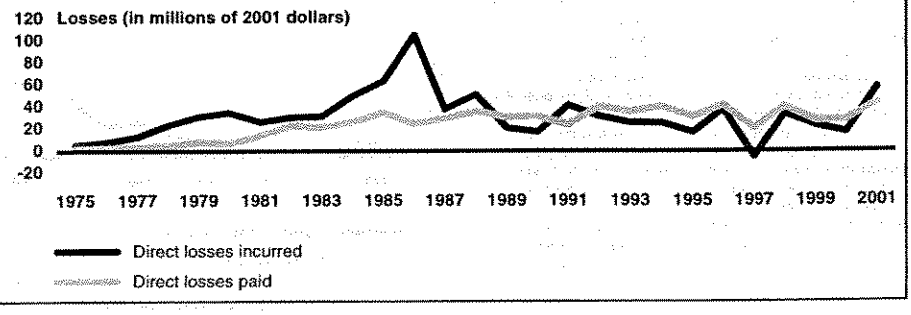
Rate regulation:
The state regulatory body--Minnesota Department of Commerce--emphasizes the market itself as the most effective regulator of premium rates in the state. Minnesota has a file and use system. In 2001, Minnesota began to allow a "speed to market" filing procedure for companies that meet certain stability and history requirements.

State tort laws:
Limits on damage awards-- No limit on economic or noneconomic damages.
Collateral source rule-- Minnesota requires a mandatory offset of collateral sources by court if defendant introduces evidence of payments made to plaintiff.
Periodic award payments-- Allows discretionary periodic payment of future damages if damages exceed $100,000.
Pretrial expert certification-- With the initial filing, plaintiff's expert must certify defendant deviated from the applicable standard of care and that deviation caused plaintiff's injuries. After 180 days, expected trial expert must certify as to the substance of facts and opinions to which expert is expected to testify, and grounds to support those opinions.
Attorney contingency fees-- No modification.
Joint and several liability-- Defendant liable only for up to four times defendant's share of damages if less than 15% responsible for harm; if more than 15% responsible, defendant liable for entire amount of damages. After August 1, 2003, defendent liable for proportioned share of damages, if less than 50% responsible for harm; if more than 50% responsible, defendant liable for entire amount of damages.
Statute of limitations-- Plaintiff must file within two years of occurrence of malpractice or termination of treatment.
Bad faith claims-- Insurer and medical society did not say these cases were an issue in Minnesota.

Premium Rates: General Surgery for Four Minnesota Insurers ($1M/$3M mature claims-made coverage)



Direct Losses Paid Compared to Direct Losses Incurred Minnesota 1975-2001



Sources: U.S. Census Bureau, 2000 (top box); GAO analysis of *Medical Liability Monitor* data (middle box); GAO analysis of A.M. Best data (bottom box).

Figure 13: Mississippi

Mississippi

Market description:

Typical coverage type and limit-- The Mississippi Department of Insurance (DOI) stated that insurance in the state is typically claims made.

Regional differences-- Insurers typically treat Mississippi as a single rating area.

Frequency and severity-- The DOI and Medical Assurance Company of Mississippi (MACM) believe claim severity has grown significantly and has led to increased insurer losses.

State specifics

Population:	2,844,658
Size (land area):	46,907 sq miles
Density:	60.6 pp/sq. mi

Insurer characteristics and market share:

Insurer characteristics-- According to a 2003 DOI survey, some physicians are moving from the admitted market to the surplus market. DOI stated that some physicians are going without formal insurance right now and hospitals might be moving to form risk retention groups or self-insure, but that captives are not allowed under state law.

Market share-- Based on A.M. Best and NAIC data, the companies with a 5% or more market share in Mississippi (2001) were MACM (34%), Reciprocal of America (21%), St. Paul Companies (10%), Doctors Insurance Reciprocal (8%), and the Doctor's Company (6%). DOI stated that MACM is the largest writer in Mississippi with an estimated market share of 60 percent. Most licensed companies, including MACM are at no growth. Several companies--St. Paul, Reciprocal of America, ProAssurance--have pulled out of the market or are reducing exposure.

Joint Underwriting Association-- DOI is currently investigating whether a JUA would be worthwhile.

Rate regulation:

The DOI stated that most medical malpractice insurance in Mississippi is presently being written in the non-admitted market (surplus lines), which is not rate or form regulated. DOI does not regulate the rates or forms of MACM because it is a non-profit, mutual insurance corporation.

State tort laws:

Limits on damage awards-- $500,000 limit on noneconomic damages, increasing to $750,000 on July 1, 2011 and $1,000,000 on July 1, 2017; limit does not apply in disfigurement cases or at the judge's discretion.

Collateral source rule-- No modification.

Periodic award payments-- No provisions for such payments.

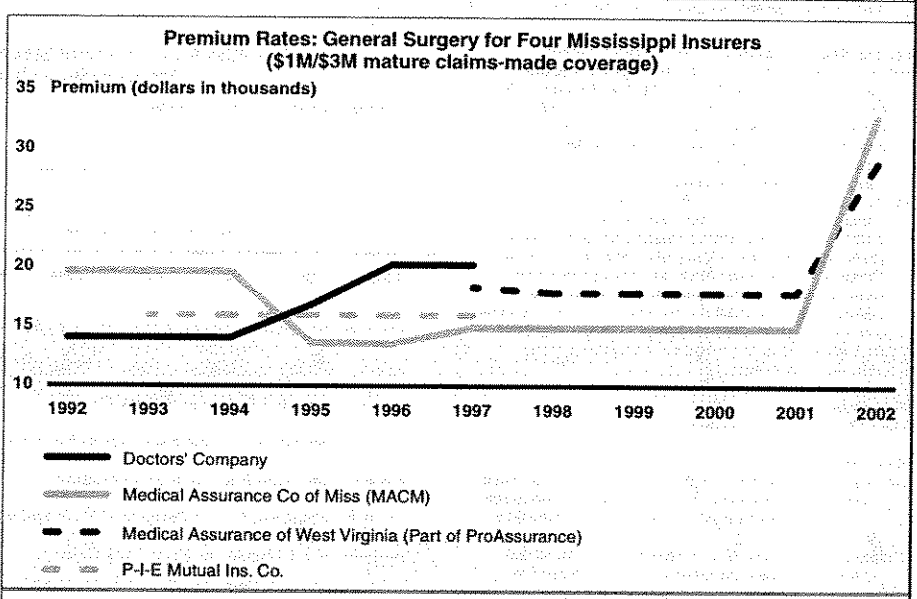
Pretrial expert certification-- Plaintiff's attorney must file a certificate of expert consultation, unless an exception to that general rule applies.

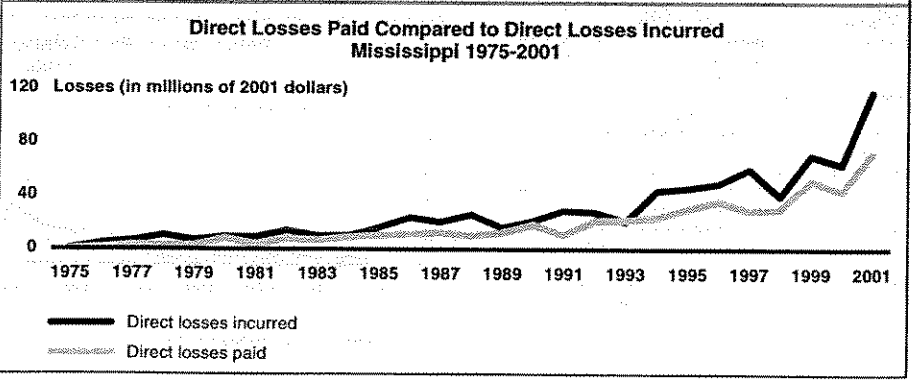
Attorney contingency fees-- No limitation.

Joint and several liability-- There is no joint and several liability for noneconomic damages in medical malpractice cases. For economic damages, Mississippi has a sliding scale, where defendants less than 30% responsible pay only their proportionate share, but defendants over 30% responsible pay up to 50% of economic damages.

Statute of limitations-- Plaintiff must file within two years of the malpractice of reasonable discovery of malpractice or seven years of the act.

Bad faith claims-- The insurer we spoke to said that it has not yet been sued for bad faith.





Sources: U.S. Census Bureau, 2000 (top box); GAO analysis of *Medical Liability Monitor* data (middle box); GAO analysis of A.M. Best data (bottom box).

Figure 14: Nevada

Nevada

Market description:

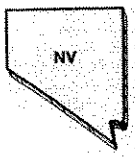
Typical coverage type and limit-- Most policies are claims-made, with the exception of a few physicians in low-risk specialties. In Nevada, most physicians are required to have $1 million/$3 million coverage.

Frequency and severity-- The State Department of Insurance (DOI) has closed-claim data indicating that frequency has increased over the past several years. The DOI believes this increase in severity is one of the main reasons insurer losses are increasing in Nevada. The Nevada State Medical Association does not believe frequency is increasing in Nevada.

Regional differences-- Insurers reporting to the Medical Liability Monitor survey typically charge higher premiums for general surgery in Las Vegas and Clark County.

State specifics

Population:	1,998,257
Size (land area):	109,826 sq miles
Density:	18.2 pp/sq. mi



Insurer characteristics and market composition:

Insurer characteristics-- In 2002, the state created Medical Liability Association of Nevada (MLAN). Although initially organized by the Insurance Commissioner, it will be an independent insurer and has the ability to convert to a mutual in the future. Also in 2002, Nevada Mutual Insurance Company (NMIC), a physician owned company, was formed and entered the market.

Market share-- Based on A.M. Best and NAIC data, the companies with a 5% or more market share in Nevada (2001) were St. Paul (32%), Health Care Indemnity Inc. (13%), the Doctors Company (9%), Physician Insurance Company of Wisconsin (6%), and Chicago Insurance Company (6%). St. Paul acquired Nevada Medical Liability Insurance (NMLI) in the mid 1990s, and captured a majority market share in Nevada. In December 2001, St. Paul announced it would be exiting the medical malpractice business.

Rate regulation:

The DOI requires prior approval of rates.

State tort laws:

Limits on damage awards-- $350,000 limit on noneconomic damages, with exception for cases of gross malpractice or special circumstances. Cap is applied per plaintiff and per defendant.

Collateral source rule-- Courts allow offsets in damages against health care providers in the amount received from a collateral source, including any prior payment by the defendant health care provider.

Periodic award payments-- Claimant may elect to receive award for future damages in a lump sum reduced to present value, if approved by the court, or by an annuity.

Pretrial expert certification-- Expert certification required to support allegations; expert must practice or have practiced in area similar to practice related to alleged malpractice.

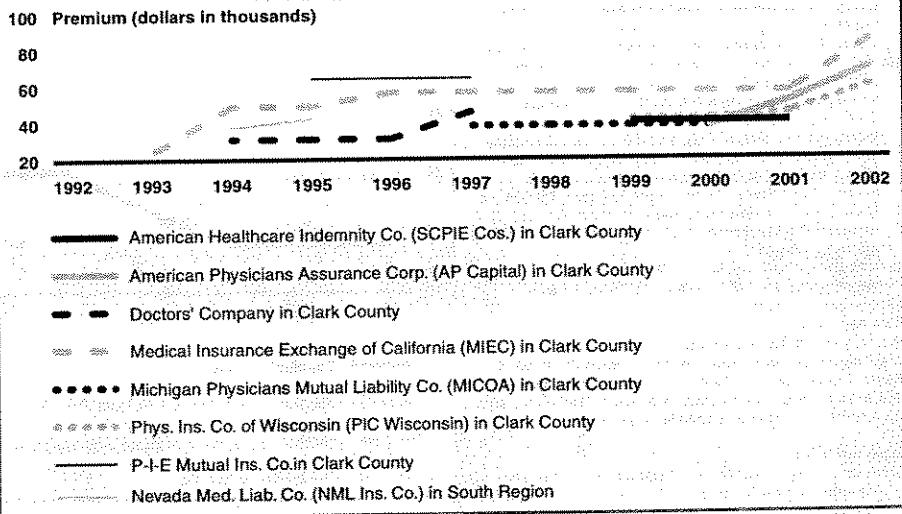
Attorney contingency fees-- No modification.

Joint and several liability-- There is no joint and several liability in Nevada in medical malpractice cases.

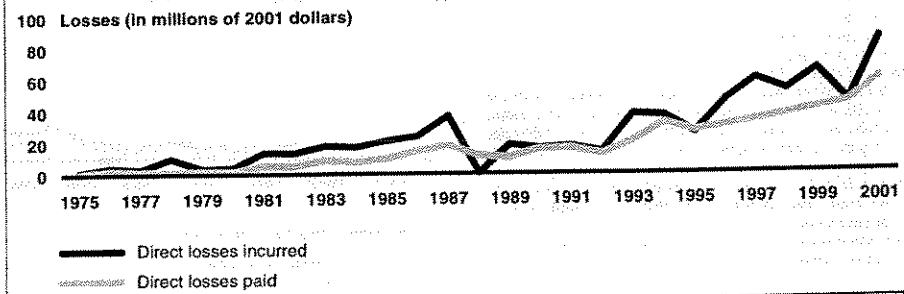
Statute of limitations-- Plaintiff must file within three years from the injury or two years from the discovery of the injury, whichever is first.

Bad faith claims-- The insurer we spoke to said it had not faced many bad faith claims in Nevada.

Premium Rates: General Surgery for Eight Nevada Insurers ($1M/$3M mature claims-made coverage)



Direct Losses Paid Compared to Direct Losses Incurred Nevada 1975-2001



Sources: U.S. Census Bureau, 2000 (top box); GAO analysis of *Medical Liability Monitor* data (middle box); GAO analysis of A.M. Best data (bottom box).

Figure 15: Pennsylvania

Pennsylvania

Market description:

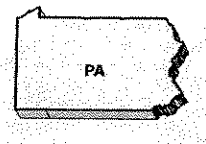
Typical coverage type and limit-- Until recently, insurers in Pennsylvania were still offering occurrence coverage. By 2003, virtually all of the insurers in Pennsylvania will offer only claims-made policies. PA requires $500,000 of private insurance; Mcare--the state sponsored patient liability fund--will insure above this amount to $1.2 million.

Frequency and severity-- The Pennsylvania Insurance Department (PID) believes severity has recently increased in PA. Both PID and Pennsylvania Medical Society Liability Insurance Company (PMSLIC) believe this change in severity is responsible for increasing insurer losses.

Regional differences-- Most insurers charge higher rates for general surgery around Philadelphia.

State specifics

Population:	12,281,054
Size (land area):	44,817 sq miles
Density:	274 pp/sq. mi



Insurer characteristics and market share:

Insurer characteristics-- As of 2002, the largest remaining medical malpractice insurer in the state is PMSLIC, a physician-owned stock company. Other entities writing in the state are commercial companies, the state Joint Underwriting Association, and self-insured academic health centers.

Market share-- Based on A.M. Best and NAIC data, the companies with a 5% or more market share in Pennsylvania (2001) were PMSLIC (19%), MIIX Insurance Company (14%), Medical Protective Company (8%), TriCentury Insurance Company (6%), Lexington Insurance Company (5.2%), and VHA Risk Retention Group Inc. (5.1%). Several large medical malpractice insurersc--Phico, MIIX, and Princeton--will have ceased writing in Pennsylvania by the end of 2003.

Joint Underwriting Association-- The JUA covers around 5 hospitals and 1500 physicians and expects 1,000 more physicians to seek coverage in the next year.

Rate regulation:

The PID generally utilizes a file and use system with the exception that it will review requests for more than a 10% increase in premium. PID only reviews small commercial risks-those under $25,000 in premium-and relies on the market to regulate large commercial risks.

State tort laws:

Limits on damage awards-- No limit on economic or noneconomic damages.

Collateral source rule-- No modification.

Periodic award payments-- No specific provisions for periodic award payments.

Pretrial expert certification-- Plaintiff's attorney must sign the original complaint, certifying that the attorney has contacted an expert who will attest to the plaintiff's case.

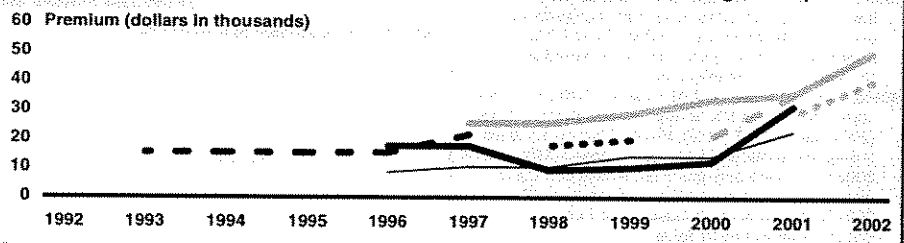
Attorney contingency fees-- No modification.

Joint and several liability-- If the defendant is less than 60% responsible for the harm, defendant is liable for only proportional share of ultimate judgment.

Statute of limitations-- Plaintiff must file within two years of malpractice or discovery of injury.

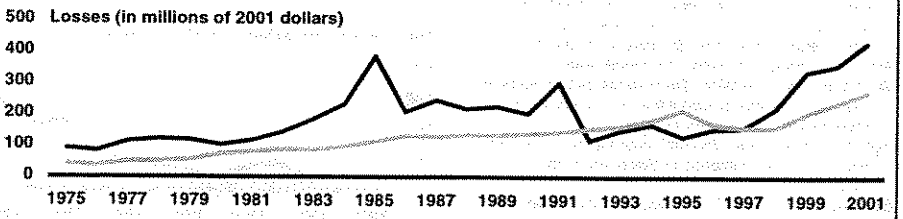
Bad faith claims-- The insurer we spoke to said that this was not a big issue in Pennsylvania.

Premium Rates: General Surgery for Seven Pennsylvania Insurers (mature claims-made coverage--see market description for coverage limits)



PHICO Insurance Co.in Delaware and Philadelphia Counties
Pennsylvania Medical Society Liability Insurance Co. (PMSLIC) in Philadelphia area
P-I-E Mutual Ins. Co.in Delaware and Philadelphia Counties
Clarendon Nat. Ins. Co. in Delaware and Philadelphia County
Professionals Advocate in Philadelphia and Delaware Counties
ProNational Ins. Co.in Philadelphia
Princeton Insurance Company

Direct Losses Paid Compared to Direct Losses Incurred Pennsylvania 1975-2001



Direct losses incurred
Direct losses paid

Sources: U.S. Census Bureau, 2000 (top box); GAO analysis of *Medical Liability Monitor* data (middle box); GAO analysis of A.M. Best data (bottom box).

Figure 16: Texas

Texas

Market description:
Typical coverage type and limit-- Majority of coverages written are claims made. Some physicians have recently lowered their coverage limits; many now have $500,000 rather than the $1 million.
Frequency and severity-- A Texas Medical Association (TMA) study has shown frequency and severity increasing in Texas. The Texas Department of Insurance (DOI) believes increases in both severity and frequency have led to increased insurer losses.
Regional differences-- Most insurers reporting to the Medical Liability Monitor survey charge higher rates for general surgery in urban areas such as Dallas and Houston, and the border county El Paso.

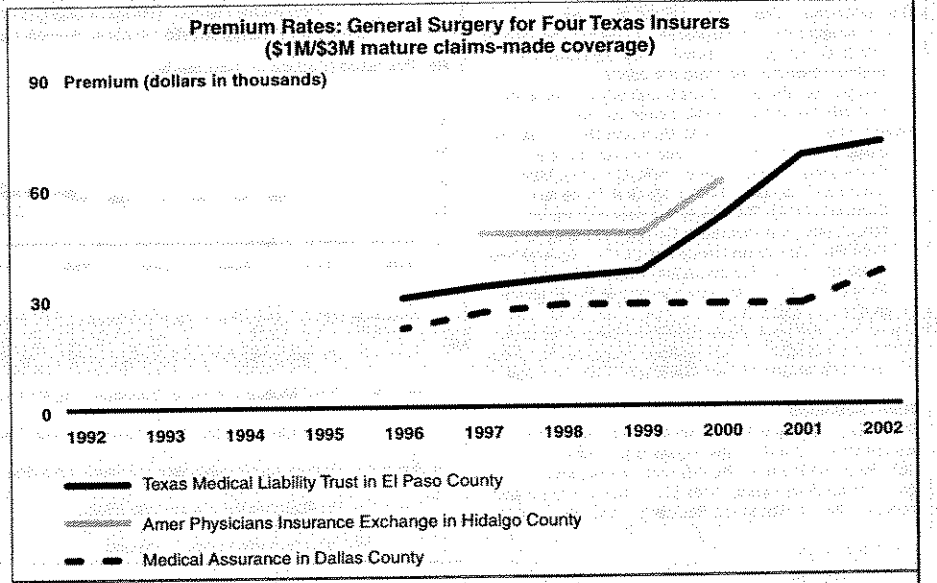
State specifics

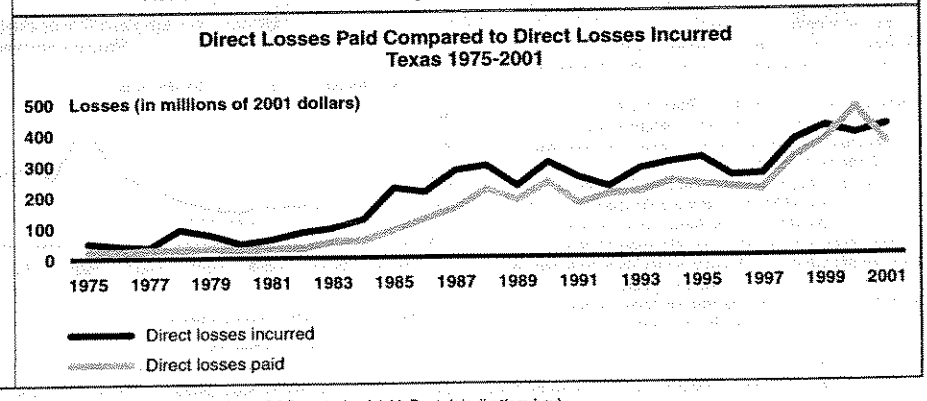
Population:	20,851,820
Size (land area):	261,797 sq miles
Density:	79.6 pp/sq. mi

Insurer characteristics and market share:
Insurer characteristics-- Licensed medical malpractice insurance carriers cover one third of physicians, unlicensed Texas Medical Liability Trust (TMLT) covers one third, and one third are covered by alternative forms of insurance.
Market share-- Based on A.M. Best and NAIC data, the companies with a 5% or more market share in Texas (2001) were TMLT (22%), Health Care Inemnity Inc. (16%), and Medical Protective Company (10%). As of 2002 there were only four main writers of medical malpractice insurance in Texas, down from 17 in 2001. Some went out of business, others discontinued writing in Texas.
Joint Underwriting Association-- Formed in 1975, the state JUA grew from 100 to 1,800 policies from the late 1990s to January 2003.

Rate regulation:
Texas is a file and use state. In the mid 1990s, the state mandated a rollback in premiums.

State tort laws:
Limits on damage awards-- Approximately $1.3 million cap on noneconomic damages in wrongful death cases. Texas applies the limit per plaintiff, per defendant, and adjusts the limit for inflation.
Collateral source rule-- No modifications.
Periodic award payments-- No specific provision for periodic award payments.
Pretrial expert certification-- Plaintiff must file either cash, a cost bond, or an expert report within 90 days of filing suit. Plaintiff must also serve expert report on each defendant within 180 days of filing suit.
Attorney contingency fees-- No modification.
Joint and several liability-- Defendants can be liable for payment of entire award if they are at least 51% responsible for plaintiff's damages.
Statute of limitations-- Plaintiff must file the case within two years of occurrence or discovery of the malpractice.
Bad faith claims-- TMLT said bad faith claims are a significant problem.





Sources: U.S. Census Bureau, 2000 (top box); GAO analysis of *Medical Liability Monitor* data (middle box); GAO analysis of A.M. Best data (bottom box).

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